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ABSTRACT

A project was undertaken to improve mental health treatment services to seriously emotionally disturbed inner city ethnic minority children. Many of these children and the majority of their parents did not speak English. As service planning began it was agreed that the developers would like to emphasize the creative arts therapies, most especially dance/movement therapy and art therapy. Since these two modalities are less culture-bound than more traditional psychotherapies and it was felt that the developers would be able to tap the unique creative expression of each child unencumbered by pressure to use English as the language of communication. The satellite treatment program began in a large elementary school with a bilingual multicultural team consisting of a clinical psychologist, social worker, two child psychiatrists, an art therapist, and a dance/movement therapist. In addition, psychology and art therapy graduate student interns assisted. Components of the program included evaluation, treatment intervention, county mental health and school personnel relationships, and creative arts therapy. (Case studies involving an 8-year-old who could not read or pay attention and a 7-year-old girl who was referred for sexually acting out behaviors and poor academics are included.) (ABL)

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CREATIVE ARTS THERAPIES IN AN INNER CITY SCHOOL

By Beth Kalish-Weiss Ph.D,ADTR

In the fall of 1987, I was working as a consultant for the Asian-Pacific Counseling Center, Los Angeles County Mental Health. The director, Joselyn Yap, asked if I would be interested in participating in a new project which would be co-sponsored by the Los Angeles Unified School District and L.A. County Dept. of Mental Health. The major goal of the project was to improve treatment services to inner city ethnic minority children who were seriously emotionally disturbed . Many of these children and the majority of their parents, did not speak English. A school had been chosen near our clinic which might serve as a model for other schools in the County.

Problems unique to ethnic minority child/family

At a national conference in 1986, sponsored by National Institute of Mental Health's Child and Family Support Branch, professionals from four major minority groups in United States convened, representing: 1)Blacks 2)Hispanics 3)Asians 4)Native Americans. Their discussions resulted in some interesting and valuable findings:

1) The most significant cultural barrier identified was the issue of assimilation into the majority culture. Conflict between

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cultures creates a natural tension between the majority/minority groups which is highly stressful for a child or adolescent.

2) A socio-cultural difference in family structures exists between the minority and the dominant culture. (e.g. heavy reliance on extended family in all four major minority groups, deference given to males in household especially in Asian families,etc)

3) The impact of use/abuse of alcohol and drugs complicates the environmental/socio-cultural problems minority children face and is recognized as a major contributing factor to their difficulties in school.

4) Perceptions of "mental health/illness" held by all four major minority groups determine whether family seeks mental health services for their children. For example,

In the Hispanic community, mental health services are viewed either as irrelevant or oppressive. It has been found that many Hispanics come in contact with a mental health professional only when forced to by the court, by welfare or by other governmental agency. Consequently, their experiences are generally negative.

In both the Hispanic and Asian cultures, families and extended families are resistive to interference from outside. Supports are expected from within the hierarchy of the family. Involvement in mental health programs is therefore viewed by the family and their community as an affirmation of a highly serious

dysfunction- often leading to family embarrassment. Similar views are held by Blacks and Native Americans.

In conceptualizing this new project, we took into consideration these findings. In addition, we were aware that environmental factors have significant influence on intrapsychic conflicts in the young child, which can effect their style of learning, their attitudes about therapists, as well as their motivation to change.

As our treatment team began to plan the services to be offered, it was agreed that we would like to emphasize the creative arts therapies, most especially dance /movement therapy and art therapy. Since these two modalities are less culture-bound than more traditional psychotherapies and it was felt we would be able to tap the unique creative expression of each child unencumbered by pressure to use English as the language of communication. Which is a necessary component in the classroom.

In January,1988 we began our satellite treatment program at The Betty Placencia Elementary School with a bilingual multicultural team consisting of the following; a licensed clinical psychologist,a licensed social worker, two child psychiatrists, an art therapist and a dance/movement therapist. In addition,psychology and art therapy graduate student interns assisted . The mental health team, all of whom were part time, have varied schedules, yet we attempt to offer treatment services

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approximately 12 to 15 hours each week on the school site in a room provided for our use. (Please refer to Fact Sheet,p 2 for type of services offered.)

Placencia is a large elementary school, even by Los Angeles standards, with a student body of 1725. Of that total, 76% are Hispanic,19% are Asian, 8% are Black and 6% are Caucasian. The neighborhood is predominantly Hispanic. It is a school encircled by gangs of Jr. high school /high school age. Yet the principal has been remarkably successful in keeping gangs off the school grounds. He has done this by maintaining strict dress codes and rules (such as no tatoos or other body markings allowed at any time.) Nevertheless, by the time boys reach sixth grade, their anxieties about gangs permeate their thinking. In this neighborhood, to reject a gang can mean total isolation, and in some cases it can be worse. To counsel such children and their families is no easy task. There are no simple solutions for them.

Major components of the on-site mental health program

I. Evaluation

Before a child is referred to the program, s/he has been through a process of evaluation which usually is initiated by the teacher or the school counselor. Following an Individual Educational Plan (IEP) meeting, where the school determines that the child needs mental health services, the child is referred to us for assessment. At that time, we administer psychological testing, movement assessment and team discussion as a baseline.

This is done in order to determine which combination of treatment services will be offered.

II Treatment intervention

The children may be seen by therapists once/ twice each week. For example, while one child may be in individual verbal psychotherapy , in group art therapy and attend an afternoon socialization group (which is voluntary), a second child may be seen in individual dance/movement therapy and in group art therapy.

All cases are reviewed in depth every four to six months, where schedule changes and progress issues are discussed. Discussion of acute crises in an individual family situation is part of our weekly team meetings.

III County Mental Health/School Personnel issues

The mental health team meets with school personnel each week for an hour and a half to discuss and share relevant information such as classroom problems, absenteeism, issues of child abuse reports, etc. These weekly meetings have served as a vital link between two systems; that of the school and of mental health. Initially, there was much caution and concern about psychotherapy on the school site. Trust has grown slowly but consistently as we have learned to work together in the best interests of the children.

In the beginning, for example, referrals were slow, even though the principal was telling us there were more than enough eligible children/families to fill our capacity number of fifteen. Three children from one highly dysfunctional family were the first

referred; during the next six months the total was up to nine children. Now, it is not unusual, for a teacher to stop one of us and ask if we would visit her classroom to observe a child she has concerns about. The mental health team has worked hard to bring about this kind of change. With the principal's support, we have spoken at teacher's meetings and distributed the FACT SHEET to them. Placencia school personnel and the mental health team presented a panel together on the AB 3632 project at a conference sponsored by California State Department of Education on identification,assessment and treatment of the seriously emotionally disturbed child last year. This linking of resources in a public way has strengthen our sense of common mission, that of offering these needy children a unique creative therapeutic experience during their school day.

Creative Arts Therapy

As mentioned earlier, art therapy and dance/movement therapy has served as a vital part of the program since its inception. The art therapist who is also a licensed Marriage,Family,Child Counselor and our former bilingual dance/movement therapist work in individual sessions and in groups with all the children. They communicate in the child's primary language of play and creativity thereby initiating a bridge to their intrapsychic and interpersonal world. In such a context, the children,(all of whom struggle with communicating in English) can more easily express their anxieties via their drawings and /or their movement improvisations. I would like to describe two short case vignettes to illustrate how the creative arts therapies have

benefited the children.

When Roberto was referred to the mental health team he was in a Special Education class, but was judged by the teacher as not able to pay attention, was constantly fidgeting in his seat and was often staring off into space, appearing at times depressed and at others highly agitated. He was 8 years old and could not read English on a first grade level, even though he had been at Placencia since kindergarten. It was the dance/movement therapist who discovered that Roberto could not learn by looking at the written word, but he was able to learn kinesthetically through his body. She set out to teach him the English alphabet by using imitation of her body movements to form the letters. Through this mode he learned quickly and experienced great pleasure in the game devised for their interaction. Concomitantly, he became more attentive in the classroom since he could better understand the tasks, and his depression lifted. Roberto has been in the AB3632 program for several years now and has made significant progress. In the art therapy group, he has drawn a series of pictures portraying his fears about gangs and drugs in his neighborhood. Recently, he has been able to talk about these anxieties with the art therapist. His primary mode of communication is no longer only on a kinesthetic level. While he still needs the classroom model offered by special education in order to master, he can at least benefit from that school environment in a meaningful way at this time.

Another child in the program, Vicky, was referred by the school when she was just seven years old, for sexually acting out

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behaviors and poor academics. The bilingual dance/movement therapist utilizing sexually explicit dolls in play therapy was able to determine that Vicky's parents were showing pornographic videotapes late at night when they thought their children were sleeping. However, the crowded living conditions were such that the two parents and 5 children were sharing two rooms. Thus, Vicky and her siblings were being overstimulated by these sexual scenes. Parent counseling helped them to understand and to cease the activities. Vicky developed a close relationship to the therapist and was able to work through many of her confused ideas about her own body image and acting out behaviors. Work with Vicky and her family continues.

These two vignettes, while all too brief and somewhat simplified for presentation, illustrate, I believe the importance of a creative arts therapy program which can work in a school environment, when both professions respect and value the unique contributions each can offer to the child with special needs.

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